MEDICAL BOARD OF CALIFORNIA
Licensing Program

WORK EXPERIENCE VERIFICATION

I am applying for Registration as a Polysomnographic Technologist/Technician/Trainee in the State of California. The Medical Board of California requires this form to be completed by the Supervising Physician. I hereby authorize release of all information in your files, favorable or otherwise.

Applicant Name:		Telephone Number:	
Address:	City:	State:	ZIP Code:
Signature of Applicant:			

THE SECTIONS BELOW MUST BE COMPLETED BY THE SUPERVISING PHYSICIAN

Name and Title of Person Completing this Form:		Telephone Number:	
Facility Name:			
Address:	City:	State:	ZIP Code:

Physician License Number: _____ State of Licensure: _____

EVALUATION OF APPLICANT

Dates of Employment: Beginning (Month/Year) _____ Ending (Month/Year) _____

1. In your opinion, is this applicant able to practice polysomnography safely? ☐ Yes ☐ No

If you answered "NO" please provide a signed and dated written explanation and any supporting documentation that may be relevant.

Applicants Name:

TASKS PERFORMED BY APPLICANT

DECLARATION

I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

_____
Print Name of Supervising Physician

_____ _____
Signature of Supervising Physician — Date Signed
Signature Stamp is not acceptable